CENTRAL DISTRICT HEALTH DEPARTMENT

To improve the health of our communities by identifying sustainable solutions to community health issues, developing partnerships for implementation of strategies, and demonstrating our success through measurement of outcomes.

MAIN OFFICE *707 N Armstrong Place, Boise, ID 83704-0825 (208) 327-7450 Fax (208) 327-8580

Patient Name_____ **Date of birth:**_____/_____/_____

SCREENING QUESTIONNAIRE FOR INTRANASAL INFLUENZA VACCINATION **For adult patients as well as parents of children to be vaccinated.** The following questions will help you determine if there is any reason we should not give you or your child Intranasal influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it. **How old are you?**_____ (you must be between 2 yrs & 49 yrs old)	YES	NO
Is the person to be vaccinated today moderately or severely ill?		
Does the person to be vaccinated have an allergy to chicken eggs or to a component of the influenza vaccine?		
Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist®) in the past?		
Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders?		
Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?		
Is the person to be vaccinated receiving aspirin therapy or aspirin-containing therapy?		
Is the person to be vaccinated pregnant or could she become pregnant within the next month?		
Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment (such as in a hospital room with reverse air flow)?		
Has the person to be vaccinated received any other vaccinations in the past 4 weeks?		
Has the person to be vaccinated ever had Guillain-Barré syndrome?		

I have read the above information about FluMist and have truthfully answered all of the questions on this form. I have also received a copy of the Vaccine Information Statement for FluMist. I have had a chance to ask questions and fully understand the benefits and risks of vaccination with FluMist. My signature below indicates my permission for FluMist to be given to me.

Signature of person receiving vaccine or the person authorized to make the request:

SIGNATURE X_____ **DATE**_____

Date _____

Nurse Signature _____

Return Date _____

(FOR NURSES USE ONLY)